

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-031326

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4102

FILED AUG 28 1962

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS City</u>		c. CITY OR TOWN <u>KANSAS City</u>	
Length of stay in lb <u>16yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6818 TRUMAN Road</u>		d. STREET ADDRESS (If outside, give location) <u>7135 Bellfontaine</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>I</u> Last <u>Stratton</u>			4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1962</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-1916</u>	9. AGE (last birthday) <u>45</u>	IF UNDER 1 YEAR Months <u>45</u> Days <u></u> Hours <u></u> Min. <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Lee Way Motor Freight</u>	11. BIRTHPLACE (City and state or country) <u>Eddy, Oklahoma</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Rock Stratton</u>	13b. MOTHER'S MAIDEN NAME <u>Bendie Bunch</u>	14. NAME OF HUSBAND OR WIFE <u>Estella M. Stratton</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> <u>NAVY U.S. W. II</u>	16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT <u>Estella M. Stratton-7135 Bellfontaine</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing of skull with multiple skull fractures + Brain injury</u> DUE TO (b) <u>Fracture of Left arm</u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Run over by truck which was out of control</u>
20c. TIME OF INJURY Hour <u>8-6.62</u> Month, Day, Year <u>aut 9 control</u>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, school, street, office bldg., etc.) <u>Street</u>
20f. CITY, TOWN, OR LOCATION <u>Hannas City, Jackson</u>		COUNTY <u>Mo</u> STATE <u>Mo</u>

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE <u>Sheil Funeral Home</u>	(Degree or title) <u></u>	22b. ADDRESS <u>6625 Pleasant St E Mo</u>	22c. DATE SIGNED <u>8-2-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-10-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Eddy, Okla.</u>	23d. LOCATION (City, town, county) <u></u> (State) <u></u>

24. FUNERAL DIRECTOR <u>Sheil Funeral Home</u>	ADDRESS <u>KC. 25, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-8-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

C. Kealhofer MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard E. Carroll

Licensed Embalmer No. 4829

P. O. Address R. E. M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.